GEORGIA DEPARTMENT OF HUMAN RESOURCES
Office of Regulatory Services
Health Care Section
2 Peachtree Street, N.W. Suite 33-250
Atlanta, Georgia 30303
Tel: 404.657.5550 Fax: 404.657.8934

REQUIRED HOSPITAL SELF REPORTS – PATIENT INCIDENTS

(Please Type or Print Form)
For Confidentiality see 290-9-7-.07(2)(a)2.

FACILITY INFORMATION

Name of Hospital: _____

Hospital Type: _____ **License #:** _____
See Chapter 290-9-7-.03(c)1

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Contact Person(s): _____ **Title:** _____

Phone Number of Contact: _____ **Fax #:** _____

Email Address: _____

Patient /Reporting Information

Date _____ **Time** _____ **a.m./p.m.** **Incident Occurred**

Date _____ **Time** _____ **a.m./p.m.** **Hospital was Aware that Reportable Incident May Have Occurred**

Date _____ **Time** _____ **a.m./p.m.** **Reported to ORS Agency**

_____ _____ _____**M/F** _____
Patient Name **Age** **Sex** **Date of Birth**

_____ _____
Medical Record # **Date of Admission**

_____
Reason for Hospital Admission

Diagnosis *(all)* (Use Narrative Format, Not ICD-9 Coding):

_____

_____

_____

Type of Incident: Please check appropriate boxes.

[ ] Any unanticipated patient death not related to the natural course of the patient's illness or underlying condition
[ ] Any surgery on the wrong patient or the wrong body part of the patient
[ ] Any rape of a patient which occurs in the hospital

Briefly describe circumstances of the incident: *(attach additional sheet if necessary)*

_____

_____

_____

_____

_____

_____

_____

_____

Immediate Corrective or Preventative Action Taken: (*attach additional sheet if necessary)*

_____

_____

_____

_____

_____

_____

Note: If the incident involved a death, was the medical examiner notified? [ ]Yes [ ] No
Was an autopsy requested? [ ] Yes [ ] No
Name and contact number of Medical Examiner_____
See Chapter 290-9-7-.1(d)1

Acknowledgement of Information Reported:

I certify that the information reported within this form is true, accurate, and complete to the best of my knowledge.

_____ _____ _____
Signature of Person Completing Form ***Title*** ***Date Completed***

_____
Print Name

For Department Use Only

Received in SA Date:_____

Reviewed By:_____

Date:_____

Reporting time frame of 24 hours/next business day met? ( ) Yes ( ) No

Action Required ( ) Yes ( ) No

Self Report ID #: _____ Complaint Number: _____

This report is required as set forth in the Hospital Rules §290-9-7-.07 (2) and must be submitted to the Department within twenty-four (24) hours or by the next regular business day from when the incident occurred, or from when the facility has reasonable cause to suspect a reportable incident §290-9-7-.07(2)(a)

For Confidentiality see 290-9-7-.07(2)(a)2.